SECTION 3
ADJUSTMENTS

Providers who are paid incorrectly for a claim should use the *Individual Adjustment Request* form to request an adjustment. For credits only, providers may also submit individual adjustments via the Internet. Adjustments may not be requested when the net difference in payment is less than $4.00, or $.25 for pharmacy, per claim. If the adjustment is due to an insurance payment, or involves Medicare, the $4.00, or $.25, minimum limitation does not apply.

In some instances, more than one change may be necessary on a claim. **All** the changes to the claim must be addressed on the same *Individual Adjustment Request* form. Specify all the changes required, addressing each change separately. Field 15 of the form may be used to provide additional information. More than one claim **cannot** be processed per *Individual Adjustment Request* form. Each adjustment request addresses one particular claim. A separate *Individual Adjustment Request* form must be completed for each claim that requires changes, even if the changes or errors are of a similar nature or are for the same patient.

If an adjustment does not appear on a Remittance Advice within 90 days of submission, a copy of the original *Individual Adjustment Request* and attachments should be resubmitted. Photocopies are acceptable. Mark this copy with the word “Tracer”. Submitting another request without indicating it as a “tracer” can further delay processing. Adjustments for claim credits submitted via the Internet get a confirmation back the next day after submission to confirm the acceptance and indicate the status of the adjustment. If the Internal Control Number (ICN) on the credit adjustment is not valid, the confirmation file indicates such. If no confirmation is received, the provider should resubmit the claim credit.

See Section 4 of the Medicaid *Provider Manual* for timely filing requirements for adjustments and claim resubmissions. *Individual Adjustment Request* forms are to be submitted to the address shown on the form.

GTE Data Services

MISSOURI MEDICAID
INDIVIDUAL ADJUSTMENT REQUEST

☐ UNDERPAYMENT

☐ OVERPAYMENT

FORWARD ORIGINAL TO:

DIV. OF MEDICAL SERVICES
ADJUSTMENT UNIT
P.O. BOX 6500
JEFFERSON CITY, MO 65102

TO FACILITATE PROCESSING, PLEASE ATTACH THE FOLLOWING:

1. Claim Copy
2. Remittance Advice Copy

PLEASE ENTER THE FOLLOWING DATA FROM YOUR REMITTANCE ADVICE

3. INTERNAL CONTROL NUMBER ☐☐☐☐☐☐☐☐☐☐☐☐☐

4. RECIPIENT MEDICAID NUMBER ☐

5. PROVIDER LABEL

6. RECIPIENT NAME _____

7. REMITTANCE ADVICE DATE _____

R.A. PAGE NUMBER _____

REFER TO PROVIDER MANUAL ADJUSTMENT SECTION FOR INSTRUCTIONS

	SERVICE DATE	INFORMATION ON REMITTANCE ADVICE	CORRECTED INFORMATION
8. QTY/UNITS			
9. NDC/PROCEDURE CODE			
10. SERVICE DATE(S)			
11. BILLED AMOUNT			
12. PAID AMOUNT			
13. PATIENT SURPLUS			
14. OTHER RESOURCES (TPL) (IDENTIFY SOURCE)			
15. OTHER/REMARKS			

16. PROVIDER'S SIGNATURE _____ TITLE _____ DATE _____

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